Kansas Department on Aging

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			7. BOILBING			
		B023016	B. WING		02/04/20	015
NAME OF PI	ROVIDER OR SUPPLIER		RESS, CITY, STA			
BRIDGE H	IAVEN VILLAGE		ARCH PARK I E, KS 66049	DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE C	(X5) OMPLETE DATE
S 000	INITIAL COMMENTS		S 000			
	an initial survey with	s represent the findings of complaint investigation amed home plus facility on 15 and 2-4-15.				
S5085 SS=D	26-42-201 (c) Function Reassessment	nal Capacity Screen	S5085			
	determine each reside according to the follow (1) At least once eve (2) following any sign as defined in K.A.R. 2	ry 365 days; nificant change in condition 26-39-100; and if the resident receives				
	This REQUIREMENT by: KAR 26-42-201(c)	is not met as evidenced				
	sample included 3 resobservation, record re (#900) of 3 sampled r to ensure designated	eview and interview for 1 residents, the operator failed staff conducted a screening sident's functional capacity				
	Findings included:					
	admission on 11-4-14 Dementia, Hypertens	resident #900 revealed with diagnoses Alzheimer's ion, Cardiovascular Accident rs, Agitation, and Allergies.				
	The Functional Capac	city Screen (FCS) upon				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		B023016	B. WING		02/04/2015	
	ROVIDER OR SUPPLIER	1701 RESE	RESS, CITY, STA ARCH PARK I E, KS 66049			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLET	ſΕ
\$5085	required supervision of toileting; independent walking/mobility and experform management treatments. Occasion Cognition: impairment memory, memory/rect Problems identified in impaired decision-mater FCS lacked revision of experienced a change. The Negotiated Service Health Services Plant dated 11-5-14 records with bathing three tim with dressing; supervice administer medication Plan (HSP) lacked heresident's current impability to feed self and Observation and interrevealed certified staff cheeseburger and free Resident sitting with expectation and prompting swallow. Certified staff chewing and sometime mouth.  Observation and interrevealed certified staff Resident was sitting in put gait belt on reside stand with walker. Stassistance and verbal	-14 recorded resident with bathing, dressing and with transfers, eating; and unable to of medications and hally incontinent of bladder. It of short term and long term all and decision-making. Cluded falls/unsteadiness, king and wandering. (The when the resident en in condition.)  The eagreement (NSA) and (HSP) upon admission es per week; Assistance ision of toileting and staff to his. The Health Services alth services to address aired mobility, impaired it risk for falls.  The resident and fries with a fork. Eyes closed chewing distaff G providing frequent and staff G stated resident will stop hes pocket food in his/her.  The resident is of and H toileting resident. In a chair at bedside. Staff and instructed resident to	S5085			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		B023016	B. WING		02/0	)4/201 <b>5</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
BRIDGE H	IAVEN VILLAGE		ARCH PARK [ E, KS 66049	DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
\$5085	resident along and re controlling his/her fee stooped over. After to attempted to ambulat chair, resident becam was assisted onto a swheelchair could be fH confirmed resident transfer and resident ago when he/she tried assistance.  Confidential interview resident #900 has har and has required two with transfers, ambula around the end of De Further confirmed the wheel chair at times of weight. Also stated reuntil around the first of linear transfers, was and that resident requiremes.  For resident #900, the the licensed nurse codetermine the resident recommender.	hat both staff pulled the sident had trouble t, shuffled, knees bent and bileting, when staff e resident back to his/her be unable to bear weight and shower chair until a bound. Certified staff G and is definitely a two person had a fall a couple of weeks do to get out of bed without with swith staff confirmed do increased difficulty walking person physical assistance action and toileting since becember or first of January. The resident has required a doubt to inability to bear desident used to feed self of January.  The staff confirmed do increased difficulty walking person physical assistance action and toileting since determined and the resident used to feed self of January.  The staff confirmed do increased to reflect accondition and the resident's as not assessed to reflect accondition and the resident's as not assessed to reflect accondition and the resident's as not assessed to reflect accondition and the resident's as not assessed to reflect accondition and the resident's as not assessed to reflect accondition and the resident's as not assessed to reflect accondition and the resident's as not assessed to reflect accondition and the resident's as not assessed to reflect accondition and the resident's as not assessed to reflect accondition and the resident's as not assessed to reflect accondition and the resident's accondition and the r	\$5085			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	1 ' '	(X3) DATE SURVEY COMPLETED	
		B023016	B. WING		02/0	4/2015	
NAME OF PI	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE	1 02.0		
BRIDGE H	IAVEN VILLAGE		ARCH PARK I E, KS 66049	DRIVE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE	
S5105	Continued From page	3	S5105				
S5105 SS=D	26-42-202 (a) Negotiated Service Agreement		S5105				
	plus shall ensure the negotiated service ag based on the resident screening, service ne collaboration with the legal representative, the agreed to by the residence representative, the renegotiated service ag following information:  (1) A description of the receive; (2) identification of the and (3) identification of each	reement shall provide the					
	This REQUIREMENT by: KAR 26-42-202(a)	is not met as evidenced					
	sample included 3 res	reement provided a vices the resident will					
	Findings included:						
	admission on 12-1-14 Hypertension, Demer	esident #800 revealed with diagnoses utia, Insulin Dependent stroesophageal Reflux					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		B023016	B. WING		02/04/2015	
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
BRIDGE H	IAVEN VILLAGE		EARCH PARK I CE, KS 66049	DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
S5105	The Functional Capaci recorded resident una medication/treatment Negotiated Service At 12-1-14 recorded faci assistance. The NSA services diabetes mai responsible for performonitoring.  Review of Medication January 2015 and phy Accuchecks (blood sua day before meals who by certified staff F, H. Interview on 1-29-15 staff C confirmed the aides are delegated to monitoring. Further of documentation of who performance of blood.	ema and Chronic Pain.  City Screen dated 12-1-14  Table to perform  management. The  greement (NSA) dated  Lity to provide medication  Lacked a description of  nagement including who is  ming blood sugar  Administration Record for  ysician's orders revealed:  gar monitoring) three times  with entries initialed as done  and I.  Lat 4:31 pm with licensed  above certified medication  to perform blood sugar  confirmed the NSA lacked  to is responsible for  sugar monitoring.  Let operator failed to ensure  a agreement provided a  vices the resident will	S5105			
S5116 SS=D	26-42-202 (d) NSA re  (d) Each administrato the review and, if neconegotiated service ag following requirement (1) At least once ever	visions r or operator shall ensure essary, revision of each reement according to the	S5116			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		B023016	B. WING		02/04/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STAT	FE, ZIP CODE	
DDIDGE I	IAVENIVII I AGE	1701 RES	SEARCH PARK D	PRIVE	
BRIDGE	IAVEN VILLAGE	LAWREN	CE, KS 66049		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
S5116	Continued From page	: 5	S5116		
	assistance with eating assistant; and (4) if requested by the legal representative, s	e resident or the resident 's staff, the case manager, or, sident or the resident 's			
	This REQUIREMENT by: KAR 26-42-202(d)	is not met as evidenced			
	sample included 3 resobservation, record re (#900) of 3 sampled r to ensure the review a negotiated service ag	eview and interview for 1 esidents, the operator failed and revision of the			
	Findings included:				
	admission on 11-4-14 Dementia, Hypertensi	resident #900 revealed with diagnoses Alzheimer's ion, Cardiovascular Accident rs, Agitation, and Allergies.			
	admission dated 11-5 required supervision validiting; independent walking/mobility and experform management treatments. Occasion Cognition: impairment memory, memory/reco	with bathing, dressing and with transfers, eating; and unable to			

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE ( A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		B023016	B. WING		02/04/2015	
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STAT	E, ZIP CODE		
DDIDGE I	14\/E\\\/!!	1701 RES	SEARCH PARK D	RIVE		
BRIDGE F	IAVEN VILLAGE	LAWREN	CE, KS 66049			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	O BE COMPLETE	
S5116	FCS lacked revision of experienced a change of the Negotiated Services Plandated 11-5-14 records with bathing three time with dressing; supervadminister medication Plan (HSP) lacked heresident's current impability to feed self and Review of Nurses Not (no time documented 11-18-14: "Staff repopain with weight bear Right knee appears stouchno bruises or States it hurts to walk to assist for safety." 11-29-14: "This nurs resident was found in floor wet where resided Signed by licensed standard standard resident sleeping con and night probably 20 meals and refuse to we Signed by licensed standard register to right knee/hip." Si	king and wandering. (The when the resident e in condition.)  ce Agreement (NSA) and (HSP) upon admission ed services for supervision es per week; Assistance ision of toileting and staff to its. The Health Services alth services to address aired mobility, impaired I risk for falls.  tes revealed the following on the entries): orts resident complains of ing to right knee and hip. wollen - knee cap tender to redness noted to knee.  a little. Gait unsteady. Staff Signed by licensed staff C. e received call stated floor in room beside bed - ent had urinated on floor" aff C. th physician, informed of in floor. Reported also tinuously throughout day in the hours - will sleep through wake up for medications." aff C. ge in resident. Continues to eady and complains of pain gned by licensed staff C. ontinues to have difficulty pain right knee/hip."	S5116	DEFICIENCY)		
	1-15-15: " Resident	continues to sleep a lot - oom but sleeps in chair.				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		B023016	B. WING		02/0	4/2015	
	ROVIDER OR SUPPLIER	1701 RESE	RESS, CITY, STA ARCH PARK D E, KS 66049				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE	
S5116	Gait increasingly unst increased sleepiness of pain to right knee/h staff C. 1-29-15: "Staff may when resident refuses closely - family, docto to encourage to ambustaff C.  Observation and interrevealed certified staft cheeseburger and free Resident sitting with expectation occasionally. Certified cueing and prompting swallow. Certified staft chewing and sometime mouth.  Observation and interrevealed certified staft Resident was sitting in put gait belt on reside stand with walker. Stand with walker. Stansistance and verbastand up. While ambustand up. After the stooped over. After the attempted to ambulate chair, resident became was assisted onto a swheelchair could be fully transfer and resident transfer and resident transfer and resident transfer and resident	teady possible related to or dizziness and complaint hip." Signed by licensed at times use wheelchair for s/can't walk - will monitor or informed and ok but staff ulate." Signed by licensed rview on 1-29-15 at 2:05 pm of G feeding resident a ench fries with a fork. Eyes closed chewing at staff G providing frequent go get resident to chew and aff G stated resident will stop hes pocket food in his/her rview on 1-29-15 at 3:13 pm of G and H toileting resident. In a chair at bedside. Staff ent and instructed resident to the staff provided physical all cueing to help resident ulating with resident to the chat both staff pulled the sident had trouble etc, shuffled, knees bent and coileting, when staff er resident back to his/her ne unable to bear weight and	S5116				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		B023016	B. WING		02/04/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
BRIDGE H	IAVEN VILLAGE		EARCH PARK I CE, KS 66049	DRIVE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
S5116	and has required two with transfers, ambula around the end of De Further confirmed the wheel chair at times dweight. Also stated reuntil around the first of Interview on 1-29-15 a staff C confirmed the and is a 2 person phy and ambulation. Consignificant change in a services plan lacked reinterventions to addreadility to feed self, appledecreased mobility and around the services plan lacked reservices plan lac	s with staff confirmed d increased difficulty walking person physical assistance ation and toileting since ecember or first of January. Fresident has required a due to inability to bear esident used to feed self of January.  at 5:16 pm with licensed resident needs a wheelchair resical assist with transfers firmed the resident had a condition and the health revision to include ess resident's decreased propriateness of diet,	S5116		
	the review and revision agreement following a condition as defined in				
S5171 SS=D		Care Services Standards of	S5171		
		vices shall be provided to staff in accordance with of practice.			
	This REQUIREMENT by: KAR 26-42-204(a)	is not met as evidenced			
	sample included 3 res	a census of 7 residents. The sidents. Based on eview and interview for 1			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C	(X3) DATE SURVEY COMPLETED		
		B023016	B. WING		02/04/2015
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE		
BRIDGE H	IAVEN VILLAGE		ICE, KS 66049	RIVE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
S5171	Continued From page	9	S5171		
	to ensure all health ca	ent by qualified staff in			
	Findings included.				
	admission on 11-4-14 Dementia, Hypertensi	resident #900 revealed with diagnoses Alzheimer's ion, Cardiovascular Accident rs, Agitation, and Allergies.			
	admission dated 11-5 required supervision validiting; independent walking/mobility and experform management treatments. Occasion Cognition: impairmen memory, memory/rec	eating; and unable to of medications and hally incontinent of bladder. t of short term and long term all and decision-making. cluded falls/unsteadiness,			
	Health Services Plan dated 11-5-14 records with bathing three tim	ce Agreement (NSA) and (HSP) upon admission ed services for supervision es per week; Assistance ision of toileting and staff to as.			
	1-18-15, assessment incident and notification Confidential interview stated on 1-18-15 res	cumentation of a fall on by a nurse following the on of family and physician.  s on 1-29-15 and 2-3-15 ident's personal alarm went found on floor laying on left			
		in his/her room next to			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		B023016	B. WING		02/0	4/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	-	
BRIDGE H	IAVEN VILLAGE		ARCH PARK I E, KS 66049	DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
S5171	Continued From page	e 10	S5171			
	licensed staff C and v signs. Staff stated re pain and remained in confirmed no nurse counted the day of the incident Interview on 1-29-15 staff C confirmed them 1-18-15 that was not physician and family confirmed there was staff were not instruct medication.  For resident #900, the all health care serviced resident by qualified succeptable standards	documented and that were not notified. Further no follow up of incident and ted to administer pain  the operator failed to ensure the shall be provided to the staff in accordance with to of practice after the a fall resulting in back pain				
S5205 SS=F	26-42-104 (a) Disaste Preparedness	er and Emergency	S5205			
	plus shall ensure the number of staff member	or operator of each home provision of a sufficient pers to take residents who nce in an emergency or ocation.				
	This REQUIREMENT by: KAR 26-42-102(a)	is not met as evidenced				
	sample included 3 res	a census of 7 residents. The sidents. Based on rview for 1 (#900) of 1				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE S COMPLE	
		B023016	B. WING		02/0	4/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
BBIDGE L	IAVEN VILLAGE	1701 RESE	ARCH PARK I	DRIVE		
BRIDGE	IAVEN VILLAGE	LAWRENC	E, KS 66049			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
S5205	Continued From page	e 11	S5205			
	residents requiring 2 operator failed to ensignations sufficient number of same residents who would recurred location.	ure the provision of a				
	Findings included:					
	resident census of 7 r	ho could require 2 staff for				
	admission on 11-4-14 Dementia, Hypertensi	resident #900 revealed with diagnoses Alzheimer's ion, Cardiovascular Accident rs, Agitation, and Allergies.				
	revealed certified staff resident and from bat in a chair at bedside. resident and instructe walker. Staff provider verbal cueing to help ambulating with reside observed that both stand resident had trou shuffled with bent knet toileting, when staff aresident back to his/h unable to bear weight shower chair until a w Certified staff G and helpinitely a two personal	chroom. Resident was sitting Staff put gait belt on and resident to stand with d physical assistance and resident stand up. While ent to the bathroom, aff pulled the resident along ble controlling his/her feet; sees and stooped over. After ttempted to ambulate er chair, resident became at and was assisted onto a wheelchair could be found. I confirmed resident is n transfer.				
	and has required two	s with staff confirmed d increased difficulty walking person physical assistance ation and toileting since				

. ,		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLI	=1ED
		B023016	B. WING		02/04/2015	
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE ZIP CODE	1 02.0	
TO WILL OF TH	TO VIDEN ON OUT FEEL		ARCH PARK [			
BRIDGE H	AVEN VILLAGE		E, KS 66049			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
S5205	Continued From page	e 12	S5205			
	around the end of December or first of January. Further confirmed the resident has required a wheel chair at times due to inability to bear weight.  Interview on 1-29-15 at 5:16 pm with licensed staff C confirmed the resident needs a wheelchair and is a 2 person physical assist with transfers and ambulation at this time. Was not aware that resident required two staff to assist with transfers and ambulation/mobility stating he/she had seen resident ambulate as recently as "this past Friday". Confirmed only one staff member had been scheduled every day from 8:00 pm until 8:00 am but now has scheduled another staff to work those hours to ensure there are 2 staff at all times.					
	the provision of a suff members to take resid	e operator failed to ensure icient number of staff dents who would require rgency or disaster to a				
S5215 SS=E	26-42-104 (d) Disaste Preparedness Educat	• •	S5215			
	(d) Each administrator or operator shall ensure disaster and emergency preparedness by ensuring the performance of the following: (1) Orientation of new employees at the time of employment to the home 's emergency management plan; (2) education of each resident upon admission to the home regarding emergency procedures; (3) quarterly review of the home 's emergency management plan with employees and residents; and					

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		B023016	B. WING		02/04/2015	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
BRIDGE H	IAVEN VILLAGE		ARCH PARK I E, KS 66049	DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
S5215	at least annually with shall include evacuation.  This REQUIREMENT by: KAR 26-42-104(d)(4)  The facility reported a sample included 3 reserview and interview failed to ensure disast preparedness by ensurements and an emeconducted at least an residents. This drill sthe residents to a section of the home plan revealed the plan review with residents, lacked documentation which included evacuated and included evacuated evacuated evacuated and included evacuated evacuate	I, which shall be conducted staff and residents. This drill on of the residents to a is not met as evidenced a census of 7 residents. The sidents. Based on record for all residents, the operator ter and emergency uring quarterly review of the anagement plan with ergency drill which shall be nually with staff and hall include evacuation of the include evacuation of the residents to a set 4:45 pm with	S5215	DEFICIENCY)		
		entation of review with the				

Kansas Department on Aging
STATEMENT OF DEFICIENCIES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		B023016	B. WING		02/04/2015	
NAME OF PI	ROVIDER OR SUPPLIER		L RESS, CITY, STA	TE, ZIP CODE	1 02/0	4/2013
BRIDGE H	IAVEN VILLAGE		ARCH PARK [ E, KS 66049	DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
S5215	disaster and emerger ensuring quarterly rev emergency managem	operator failed to ensure ncy preparedness by view of the home's nent plan with residents and nich shall be conducted at	S5215			
\$5265 \$S=D	Assessment  (a) Self-administration resident may self-administration resident may self-administration medications independent medication container licensed nurse or phamember or friend progratuitously, if a licensessessment and deterministration without staff assistant (1) An assessment shresident initially begin medication, if the resident	ninister and manage dently or by using a or syringe prefilled by a armacist or by a family viding this service sed nurse has performed an armined that the resident can safely and accurately ce. nall be completed before the as self-administration of	S5265			
	by: KAR 26-42-205(a)(1) The facility reported a sample included 3 res review and interview	a census of 7 residents. The sidents. Based on record for 1 (#800) of 1 sampled in, the operator failed to				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			
		B023016	B. WING		02/	/04/2015
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE			
BRIDGE H	IAVEN VILLAGE		SEARCH PARK DF ICE, KS 66049	RIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
S5265	safely inject insulin; a assessment was com resident began self-in Findings included:  Record review for readmission on 12-1-14 Hypertension, Demer Diabetes Mellitus, Ga Disorder, Debility, Editor The Functional Capac recorded resident una medication/treatment Negotiated Service At 12-1-14 recorded faci assistance.  Review of Medication January 2015 and physical Soliding Scale Novolog 150-200, 1 unit; 201-2 units; 301-350, 4 units Lantus 25 units subcut Observation and interrevealed resident aler place watching televis "the nurses here give indicated it was admin Observation of both s revealed small purple arm and 1 on left upp	urse performed an nine the resident's ability to nd failed to ensure this pleted initially before the jection of insulin.  esident #800 revealed with diagnoses atia, Insulin Dependent stroesophageal Reflux ema and Chronic Pain.  city Screen dated 12-1-14 able to perform management. The greement (NSA) dated lity to provide medication  Administration Record for sysician's orders revealed: g Flexpen for Glucose 250, 2 units; 251-300, 3 as; over 351, 5 units. Itaneously at bedtime.  Eview on 1-29-15 at 3:15 pm at and oriented to self and sion and crocheting. Stated, me my insulin" and nistered in his/her arms. houlders (deltoid region) bruises: two on right upper	S5265			
		ng scale chart, dial it up on				

Kansas Department on Aging
STATEMENT OF DEFICIENCIES

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		B023016	B. WING		02/04/2015	
	ROVIDER OR SUPPLIER	1701 RESE	RESS, CITY, STA ARCH PARK D E, KS 66049	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
S5265	to self-inject, we notify and give it." Further's gives it in his/her shown Interviews on 2-3-15 awith certified staff F a #800 self-injected the Interview on 1-29-15 staff C confirmed the documentation of the inject insulin.  For resident #800, the the licensed nurse pedetermine the resider insulin; and failed to ecompleted initially bef self-injection of insuling the self-injection of insuling gives in the licensed nurse pedetermine the resider insuling and failed to ecomplete initially before the self-injection of insuling gives it in his/her shows the self-injection gives it in his/her shows the self-injection gives it in his/her shows the self-injection gives it in	o him/her. If he/she refuses y the nurses and they come stated the resident usually ulders.  at 10:50 and and 11:00 am and I both stated resident insulin in his/her stomach.  at 4:31 pm with licensed record lacked resident's ability to safely  e operator failed to ensure enformed an assessment to not's ability to safely inject ensure this assessment was fore the resident began	S5265			
SS=D	administration of a readministrator or operamedications and biolothat resident in according provider's written or of practice, and each recommendations. The shall ensure that all of the control of the	ne is responsible for the sident 's medications, the ator shall ensure that all ogicals are administered to dance with a medical care der, professional standards manufacturer 's he administrator or operator of the following are met: reses and medication aides manage medications for responsibility.				

Nansas L	repartifient on Aging						
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	COMPLETED	
			D. WING				
		B023016	B. WING		02/0	14/2015	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ATE, ZIP CODE			
			, ,	•			
BRIDGE H	IAVEN VILLAGE		EARCH PARK	DRIVE			
		LAWREN	CE, KS 66049				
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		COMPLETE DATE	
TAG	REGULATORT OR I	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	NATE	D/112	
			+	,			
S5300	Continued From page	e 17	S5300				
	1 0						
	This REQUIREMENT	「 is not met as evidenced					
	by:						
	KAR 26-42-205(d)						
	The facility reported a	a census of 7 residents. The					
		sidents. Based on record					
	T	for 1 (#900) of 3 sampled					
		tor failed to ensure all					
	•						
		ministered to the resident in					
		edical care provider's written					
	order and professiona	al standards of practice.					
	Findings included:						
	- Record review for	resident #900 revealed					
	admission on 11-4-14	with diagnoses Alzheimer's					
		ion, Cardiovascular Accident					
		rs, Agitation, and Allergies.					
	-	, <b>3</b> , <b>3</b>					
	The Functional Cana	city Screen (FCS) upon					
	-	5-14 recorded resident					
		anagement of medications					
	and treatments. The	-					
		d Health Services Plan					
	· / !	on dated 11-5-14 recorded					
	services for staff to a	dminister medications.					
	Medication Administra	ation Record and Physician's					
	order (effective 11-4-	14):					
		grams) tablet. Give 1 to 1					
		ry 6 hours as needed for					
	pain or temp.						
	F = 6. 10.11þ.						
	Review of Nurses No	tes revealed the following					
	(no time documented						
	11-4-14: "Kignt kne	ee slightly swollen and					

Kansas Department on Aging

mg.

STATEMEN	F OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _	A. BUILDING:		COMPLETED	
			D WING				
		B023016	B. WING		02/0	04/2015	
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE			
BRIDGE H	IAVEN VILLAGE		SEARCH PARK D	DRIVE			
	-	LAWREN	CE, KS 66049				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE	
S5300	Continued From page	e 18	S5300				
	complains of pain to a ambulation." Signed record lacked documination of 500 mg. 11-18-14: "Staff repain with weight bear Right knee appears stouch no bruises or States it hurts to walk to assist for safety." The record lacked do administration of Tyle 11-19-14: "Spoke with complaining of right knad issues with this firmonitor closely." Signecord lacked documination of 500 mg or insadminister for pain con 12-12-14: "No chansleep a lot - gait unstein right knee/hip." Signet hot complained of pain to licensed staff C. The documentation of administration of admin	right knee/hip with by licensed staff C. The entation of administration of orts resident complains of ing to right knee and hip. It wollen - knee cap tender to redness noted to knee.  It a little. Gait unsteady. Staff Signed by licensed staff C. cumentation of mol 500 mg.  It family regarding resident thee pain. Family states has for a while, Arthritis. Will need by licensed staff C. The entation of administration of structions to staff to control.  Inge in resident. Continues to eady and complains of pain signed by licensed staff C. cumentation of mol 500 mg.  Is gait unsteady and oright knee/hip." Signed by record lacked ministration of Tylenol 500 montinues to have difficulty pain right knee/hip. "  It aff C. The record lacked ministration of Tylenol 500 masingly unsteady possible sleepiness or dizziness and light knee/hip." Signed by "Signed					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		B023016	B. WING		02/0	4/2015
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
BRIDGE H	IAVEN VILLAGE		EARCH PARK	DRIVE		
0400.45	CLIMMA DV. CT	ATEMENT OF DEFICIENCIES	CE, KS 66049	PROVIDER'S PLAN OF CORRECTION	<u></u>	0/5
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
S5300	Continued From page	: 19	S5300			
	1-20-15: "Family mer resident's complaints knee/hip - difficulty was taff C. The record la administration of Tyle 1-28-15: "Spoke with for x-ray right knee/hip refusing to walk." Sig The record lacked do administration of Tyle 1-29-15: "Results of dislocation - Degenerations by licensed staff C confirmed he/s pain in right knee/hip order for a routine pain his/her right knee/hip certified staff had not administer Tylenol PR	mber here - discussed of increased pain in alking." Signed by licensed ocked documentation of nol 500 mg. physician - order received prelated to pain and oned by licensed staff C. cumentation of nol 500 mg. f x-rayno acute fracture or ative Osteoarthritis "aff C. t 12:35 pm with licensed she was aware resident had and resident did not have an n medication to manage pain. Further confirmed the been instructed to the confirmed the confirmed with professional				
	all medications were a in accordance with the written order and prof practice when the res	ident experienced ongoing and licensed staff failed to taff to administer pain				
S5315 SS=F	(h) Storage. Licensed aides shall ensure that	nurses and medication	S5315			

Kansas Department on Aging

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	\ '	(X3) DATE SURVEY COMPLETED	
		B023016	B. WING	B. WING		04/2015	
NAME OF D	ROVIDER OR SUPPLIER		DDRESS, CITY, STAT	E ZID CODE			
NAME OF T	TOVIDER OR 301 1 EIER		SEARCH PARK D				
BRIDGE H	IAVEN VILLAGE		CE, KS 66049	RIVE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE	
S5315	Continued From page	20	S5315				
	accordance with each recommendations or provider and with federegulations.  (1) Licensed nurses of store non-controlled managed by the hom room, cabinet, or medication controlled medication separately locked commedication room, cab Only licensed nurses have access to the stabiologicals.  (2) Each resident managelf-administering memedications in a place the resident, licensed aides.  (3) Any resident who and is unable to proving recommended by the provider may request stored by the home.  (4) A licensed nurse of administer medications or proving the medications of the provider may request stored by the home.	those of the pharmacy eral and state laws and or medication aides shall medications and biologicals e in a locked medication dication cart. Licensed in aides shall store is managed by the home in inpartments within a locked binet, or medication cart. and medication aides shall ored medications and maging and dication shall store e that is accessible only to nurses, and medication self-administers medication					
	This REQUIREMENT by: KAR 26-42-205(h)(1)	is not met as evidenced					
	The facility reported a census of 7 residents. The sample included 3 residents. Based on observation and interview, the licensed nurses						

and medication aides failed to ensure all

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		B023016	B. WING		02/04	1/2015
NAME OF PI	ROVIDER OR SUPPLIER		RESS, CITY, STA			
BRIDGE H	IAVEN VILLAGE		ARCH PARK I E, KS 66049	JRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
S5315	5 Continued From page 21		S5315			
	medications are secu accordance with the recommendations.	rely and properly stored in manufacturer's				
	Findings included:					
	the following: 1 vial of tuberculin ski 11-14-14 open and had	9-15 at 11:55 am revealed in testing solution filled on alf full. The vial lacked e when it was opened. d staff C and removed to be				
	Lantus and Novolog insulin pens in the refrigerator.  1 open and in-use Novolog insulin pen 100 units/milliliter, for resident #800. Lacked documentation of date when opened.  1 open and in-use Lantus Solostar insulin pen 100 units/milliliter, for resident #800. Lacked documentation of date when opened.					
	with licensed staff C a confirmed in-use insu	alin pens were always stored ated they did not know the to be stored at room				
S5328 SS=F	26-42-205 (I) (3) Med Documentation	lication Regimen Review	S5328			
	(3) The administrator	or operator, or the				

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		
		B023016	B. WING		02/	/04/2015
	ROVIDER OR SUPPLIER	1701 RE	DDRESS, CITY, STATE SEARCH PARK DR ICE, KS 66049			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
S5328	record.	e that the medication ot in each resident 's clinical	S5328			
	This REQUIREMENT by: KAR 26-42-205(I)(3)	is not met as evidenced				
	The facility reported a census of 7 residents. The sample included 3 residents. Based on record review and interview for 2 (#800, #900) of 2 sampled residents with medication regimen reviews and potentially affecting all residents, the operator failed to ensure that the medication regimen review is kept in each resident's clinical record.					
	Findings included:					
	admission on 12-1-14 Hypertension, Demer Diabetes Mellitus, Ga	esident #800 revealed with diagnoses tia, Insulin Dependent stroesophageal Reflux ema and Chronic Pain.				
	recorded resident una medication/treatment Negotiated Service A	management. The greement and Health I2-1-14 recorded services				
	The record lacked domanagement review.	cumentation of a medication				
	admission on 11-4-14 Dementia, Hypertens	resident #900 revealed with diagnoses Alzheimer's ion, Cardiovascular Accident rs, Agitation, and Allergies.				

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		B023016	B. WING		02/04/2015	
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA			
BRIDGE H	IAVEN VILLAGE		EARCH PARK I CE, KS 66049	DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE	
S5328	Continued From page	23	S5328			
	recorded resident una of medications/treatm Service Agreement at dated 11-5-14 recorded administer medication.  The record lacked doregimen review.  Interview on 1-29-15 staff C stated consulting medication regiment about 2 weeks later preport. (Licensed staff medication regimen restated "The drug regiment of the drug regiment of the drug regiments and comments/recomments summary lacked docuresidents.) Confirmed documentation of the	and Health Services Plan and Health Services For staff staff to as.  cumentation of a medication  at 2:45 pm with licensed ang pharmacist performed a review on 12-18-14 and rovided a written summary and a ceview summary report which are review has been resident for the month of indicated 4 total addation noted. The amentation specific to any all resident records lacked and #900 and potentially at the operator failed to reation regimen review is kept				